

First Quarter 2001 Summary of Incidents, Complaints, Enforcement Actions

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“Any complaints and or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051 (d). The text of these summaries will not appear in this report.”

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SUMMARY OF INCIDENTS FOR FIRST QUARTER 2001

I-7688 - Leaking Sources - Computalog Wireline Products - Forth Worth, Texas

On December 14, 2000, the Licensee notified the Agency that a 45 millicurie cesium-137 well logging source was determined to be leaking on December 12, 2000. The Licensee received three new well logging sources from the manufacturer. The source package surface was wipe tested upon receipt, with no contamination detected, but the sources were not leak tested because they were new and had leak test records from the manufacturer. Two of the sources were loaded into well logging tool source holders and shipped to a Licensee's site in Canada. Contamination was subsequently detected on the table top and tools used to load the sources into the source holders. It was thought to be contamination from earlier work. The site in Canada determined the source holders were contaminated, and sent the holders and sources back to the manufacturer for inspection. It was determined that one of the sources was leaking, and had contaminated the other two sources and the shipping containers. All contamination was cleaned and no individuals were exposed to radiation in excess of regulatory limits. To prevent a recurrence of facility contamination, the Licensee will wipe test sources in addition to the outsides of packages.

File Closed.

I-7689 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7690 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7691 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7692 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7693 - Equipment Damaged - Texas Department of Transportation - Fort Worth, Texas

On January 8, 2001, the Licensee notified the Agency that a nuclear gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source was involved in a fire on January 6, 2001. The gauge was heavily damaged by the fire. A leak test of the sources in the gauge after the fire determined that the sources were not leaking. The gauge was moved to storage at another facility until it could be used as a trade-in for a replacement gauge. The Licensee was cited for failure to submit a written report to the Agency within 30 days.

File Closed.

I-7694 - Lost Radioactive Material - Pro Inspection, Incorporated - Odessa, Texas

On January 11, 2001, the Licensee notified the Agency that a radiography device containing 32 curies of iridium-192 was lost on January 11, 2001. The device was recovered about one hour after it was reported missing. Two radiographers finished work at one temporary job site, drove to lunch, then drove to another job site. Upon arrival at the second job site, the radiographers realized the radiography device was not in the back of the truck. The radiographers believe the device either fell out of the truck bed during travel or was stolen from the unattended truck during lunch. The local police found the undamaged device in the roadway about 15 miles from the first job site. The only people believed to have come in contact with the device were the local police and the local fire department's hazmat team. No members of the public are believed to have received excessive radiation exposures. The Licensee was cited for failure to secure a source of radiation against unauthorized removal. The incident was referred for escalated enforcement actions.

File Closed.

I-7695 - Lost Moisture/Density Gauge - Reed Engineering Group - Houston, Texas

On December 20, 2000, the Licensee notified the Agency that a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source had been lost from a construction site in San Antonio, Texas. The equipment operator had completed density measurements at the site and returned to his truck to perform calculations. The gauge was placed on the tailgate of the truck. Other workers approached the truck and invited the operator to lunch. He drove away from the site without placing the gauge in its transport container or securing the container to the bed of the truck as required by company Operating and Safety Procedures. When the operator remembered the gauge's position he immediately stopped and discovered the gauge was missing. He retraced his route but did not find the gauge. The missing gauge was reported to the company radiation safety officer, the Agency, and the local police department. A reward was offered and posted in a local newspaper. The gauge has not been recovered. The Licensee was cited for failure to follow established Operating and Safety procedures and for failure to secure radioactive material from unauthorized removal or access.

File Inactive.

I-7696 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7697 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7698 - Radioactive Material at Landfill - University of Texas Medical Branch/BFI - Galveston, Texas

On March 2, 2001, the landfill notified the Agency that a trash truck activated the radiation alarm at the landfill. An Agency investigation determined the trash contained contaminated medical waste. A survey located a plastic bag with radiation levels of five to seven millirems per hour on the surface. A radioactive waste disposal manifest, found inside the bag, indicated it contained technetium-99m, and the name of a hospital as generator of the trash. To prevent further human exposure, the landfill buried the bag. The Licensee was cited for failure to prevent unauthorized removal of radioactive waste and for failure to allow radioactive material to decay in storage prior to disposal in a sanitary landfill.

File Closed.

I-7699 - Source Abandoned Downhole - Halliburton Energy Services - Houston, Texas

On January 16, 2001, the Licensee notified the Agency that a 1.5 curie cesium-137 source and a 18.5 curie americium-241 source were to be abandoned downhole. Attempts to retrieve the sources were unsuccessful. The sources were immobilized at 12,758 feet by placement of a 1000 foot red-dyed cement plug. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7700 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7701 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7702 - Found Radioactive Material - SMI-TX - Sequin, Texas

On August 8, 2000, the Licensee notified the Agency that a radioactive source was found in a load of scrap metal on June 6, 2000. The source was analyzed at an offsite laboratory and identified as 0.75 millicuries of radium-226. The steel mill arranged for disposal through a licensed company.

File Closed.

I-7703 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7704 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7705 - Equipment Malfunction - Technical Welding Laboratory, Inc. / LAMCO & Associates - Pasadena / The Woodlands, Texas

On February 1, 2001, the Licensee notified the Agency of an equipment malfunction on January 31, 2001. A 68 curie iridium-192 source could not be retracted to the fully shielded position after completion of the first radiograph of the day. A consultant retrieved the source to the fully shielded position and no individual received more than a 190 millirem exposure. Inspection of the equipment revealed a slight bend in the drive cable, but attempts to repeat the stuck source were unsuccessful. The Licensee suspected the configuration of the guide tube inside the pipe caused severe bending of the guide tube that resulted in the source hang up.

File Closed.

I-7706 - Found Radioactive Material - SMI - Seguin, Texas

On December 12, 2000, the Licensee notified the Agency that a radioactive source was found in a load of scrap metal on November 17, 2000. The source was analyzed at an offsite laboratory and identified as 0.0007 millicuries of radium-226. The Licensee arranged for disposal through a licensed company.

File Closed.

I-7707 - Stolen Moisture/Density Gauge - Rone Engineers - Dallas, Texas

On February 5, 2001, the Licensee notified the Agency that a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source was stolen from a company vehicle on February 3, 2001. The driver had the gauge properly secured in his vehicle when he stopped for lunch. The gauge, lock, and security chain were all missing from the bed of the vehicle when the operator returned to his truck. The Licensee notified the police and the manufacturer and posted a reward offer in the newspaper. On February 14, 2001, the Dallas Fire Department notified the Agency that a gauge had been found at a local motel. An Agency investigation determined this gauge was the stolen gauge. The gauge was without its transport container and test block. The Licensee took possession of the gauge. A leak test confirmed that the sources were not leaking.

File Closed.

I-7708 - Radioactive Material at Landfill- BFI Landfill - Houston, Texas

On January 24, 2001, the landfill notified the Agency that a trash truck activated the radiation alarm at the landfill. An Agency investigation found radiation levels of 0.2 - 0.4 millirems per hour at the surface of three large trash bags. The bags contained wet bathroom tissue paper. The radiation is believed to have resulted from the excreta of an individual who had a nuclear medicine procedure. The waste was buried at the landfill.

File Closed.

I-7709 - Overexposure - Technical Welding Laboratory, Inc. - Pasadena, Texas

On January 19, 2001, the Licensee notified the Agency of a 5,370 millirem exposure to a radiographer during the year 2000 monitoring period. The exposure was a yearly accumulation with no incident contributing to the exposure. The Licensee was cited for permitting occupational exposure greater than the annual limit.

File Closed.

I-7710 - Stolen Moisture/Density Gauge - Drash Consulting Engineering - Harlingen, Texas

On January 30, 2001, the Licensee notified the Agency that a moisture density gauge was stolen on January 1, 2001. The gauge contained a 10 millicurie cesium-137 source and a 40 millicurie americium-241 source. The gauge was stolen from the back of a pickup truck that was parked at an apartment complex. The gauge was in a case, locked, and secured in the truck bed with chains. When the gauge operator returned to the truck, he noticed the gauge case was cracked open and the gauge was missing. The Licensee placed an advertisement in the local newspaper offering a reward for the return of the gauge. The Agency notified surrounding states and the device manufacturer. On February 28, 2001, the manufacturer was contacted by an individual whose friend found the gauge. The finder kept the gauge secured in an isolated area. The Agency verified the gauge serial numbers, contacted the Licensee, and facilitated arrangements for the return of the gauge. The Licensee determined the gauge was undamaged and a leak test of the sources confirmed no leakage.

File Closed.

I-7711 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7712 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7713 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7714 - Radioactive Material Incinerated - Safety Kleen, Inc. - Deer Park, Texas

On January 31, 2001, the company notified the Agency that waste containing naturally occurring radioactive material (NORM) had been inadvertently incinerated on January 7 & 8, 2001. The incident did not lead to any exposure to the public. The personnel handling the waste wore tyvek suits and full face respirators with supplied air. Radium-226 is not considered volatile and remains in the solid residue. The company is permitted for commercial hazardous waste incineration but is prohibited from accepting radioactive waste. The inadvertently company received a roll off bin of hazardous waste dewatering solids from a customer. The incoming shipment was monitored for radioactivity on January 2, 2001. Personnel recorded readings of 45-110 microrems per hour on the bin surface. A sample of the waste was taken for analysis. The bin was set aside and the waste generator was contacted. During the weekend a mixup occurred and the following week

the bin was routinely incinerated. The incineration resulted in six bins of ash. Five of the bins have below regulated concentrations of NORM and will be disposed of onsite, if the Texas Natural Resource Conservation Commission approves, and one bin with regulated concentrations of NORM will be sent to an authorized disposal site.

File Closed.

I-7715 - Radioactive material Found - Chaparral Steel - Midlothian, Texas

On February 2, 2001, the Licensee notified the Agency that an unidentified radioactive source had been detected in a load of scrap. An authorized licensee took possession of the source, identified it as 7 millicuries of barium-133, and will dispose of it.

File Closed.

I-7716 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7717 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7718 - Stolen Moisture/Density Gauge - QC Laboratories - Houston, Texas

On February 19, 2001, the Licensee notified the Agency that a moisture density gauge containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241 source was missing. On February 15, 2001, an employee left the Licensee's office with the gauge to travel to a job site. Four days passed and the employee had not returned to the office. The local police were notified of the missing person, truck, and gauge. The truck was located parked at a drug rehabilitation center with the gauge locked in the back. The employee had checked himself into the center. The gauge was recovered undamaged. The Licensee was cited for: failure to keep a licensed source of radiation under constant surveillance or otherwise controlled to prevent unauthorized use; failure to maintain security of a vehicle containing a gauge; failure to store the gauge in the area designated by License Condition; failure to follow emergency procedures; and failure to make a written report to the Agency within thirty days after making the telephone report.

File Closed.

I-7719 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7720 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7721 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7722 - Overexposure - Non-Destructive Inspection Corporation - Clute, Texas

On February 20, 2001, the Licensee notified the Agency of a 5,964 millirem whole body exposure to a radiographer during the year 2000 monitoring period. An Agency investigation determined the radiographer worked in fabrication shops with limited shielding. The Licensee believes the radiographer had poor work habits. To prevent a recurrence, the Licensee placed the radiographer on probation and limited his allowable exposure to 335 millirems per month. The Licensee was cited for permitting an individual to receive radiation exposures greater than the annual limits.

File Closed.

I-7723 - Badge Overexposure - Non-Destructive Inspection Corporation - Clute, Texas

On February 20, 2001, the Licensee notified the Agency of a 5,661 millirem whole body exposure to a radiographer during the year 2000 monitoring period. An Agency investigator determined that a 2,207 millirem exposure was recorded during the November 20, 2000, to December 19, 2000, monitoring period. The radiographer had dropped his personnel monitor but later found it in an unrestricted area. He believed the badge had not been exposed and did not report it to the radiation safety officer. The radiographer's pocket dosimeter indicated a 10 millirem exposure. A deletion was granted and a 417 millirem assessment, based on pocket dosimeter records and average monthly exposures, was accepted.

File Closed.

I-7724 - Overexposure - Non-Destructive Inspection Corporation - Clute, Texas

On February 20, 2001, the Licensee notified the Agency of a 5,381 millirem whole body exposure to a radiographer during the year 2000 monitoring period. An Agency investigation determined the radiographer worked in areas with insufficient shielding. The Licensee placed the radiographer on probation for six months and limited exposure to 335 millirems per month. The Licensee was cited for permitting an individual to receive radiation exposures greater than the annual limits.

File Closed.

I-7725 - Overexposure - Non-Destructive Inspection Corporation - Clute, Texas

On February 20, 2001, the Licensee notified the Agency of a 5,381 millirem whole body exposure to a radiographer during the year 2000 monitoring period. An Agency investigation determined the radiographer received the overexposure while working for more than one Licensee during the year. The total exposure was determined when the exposures from each Licensee were totaled. Each Licensee was cited for allowing the employee to received radiation exposures greater than annual limits.

File Closed.

I-7726 - Stolen Moisture/Density Gauge - Terracon Incorporated - Houston, Texas

On February 23, 2001, the Licensee notified the Agency that a truck containing a moisture density gauge was stolen. The gauge contained an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source. A technician checked the gauge out for use at a job site on February 21, 2001. The technician did not report for work the following day and did not contact the Licensee until Friday, February 23, 2001 to report the theft. The Licensee notified the local police. On February 27, 2001, the City of New Orleans Police Department located the truck. The truck was found parked in front of a residence in New Orleans with the gauge chained and locked in the back. The gauge and truck were returned undamaged. To prevent a recurrence, the technician's employment was terminated. The Licensee was cited for: failure to secure a source of radiation from unauthorized removal or access; failure to keep a source of radiation under constant surveillance or otherwise controlled to prevent unauthorized use; failure to return a gauge to storage; and failure to follow emergency procedures.

File Closed.

I-7727 - Badge Overexposure - Bonded Inspections Incorporated - Garland, Texas

On February 25, 2001, the Licensee notified the Agency of a 4,064 millirem exposure to a radiographer during the December 25, 2000 through January 24, 2001 monitoring period that resulted in an annual exposure of 6,297 millirem for the year 2000. The Licensee believes the exposure was to the badge only. The radiographer remembered dropping the badge during radiography operations but did not believe it had been exposed. The radiographer did not report the dropped badge to the Licensee's radiation safety officer. A deletion was granted and a 203-millirem assessment was accepted.

File Closed.

I-7728 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7729 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7730 - Damaged Equipment - MLA Labs Incorporated - Austin, Texas

On March 12, 2001, the Licensee notified the Agency that a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source was damaged. The gauge was run over by a compacter at a construction site. An Agency investigation determined the source shielding was not breached and no contamination resulted. The gauge was returned to the manufacturer for disposal. To prevent a recurrence, the Licensee counseled the technician. The Licensee was cited for failure to keep a source of radiation in an unrestricted area under constant surveillance.

File Closed.

I-7731 - Radioactive Material Lost - Union Carbide Chemicals - Seadrift, Texas

On December 14, 2001, the Licensee notified the Agency that a 750 millicurie, cesium-137 gauge could not be located and had not been on facility leak test records since 1977. No documents of transfer or disposal could be located by the Licensee. An intensive search of the facility has not located the gauge.

File Inactive.

I-7732 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7733 - Radioactive Material Lost - Ludlum Measurements - Sweetwater, Texas

On February 13, 2001, the Licensee notified the Agency that a 0.0114 microcurie, plutonium-239, sealed source could not be located on January 8, 2001. Visual searches for the source were conducted by the radiation safety officer and other staff without success. Due to the low activity of the source overexposure to occupationally exposed personnel and members of the public is highly unlikely. To prevent a recurrence all personnel who use any source have been given copies of the Licensee's standard operating procedure (SOP) which explains proper use and storage of radioactive sources. The SOP was also reviewed verbally with all personnel by the facility radiation safety officer. The Licensee was cited for failure to notify the Agency within 30 days of determining the source was missing.

File Closed.

I-7734 - Radioactive Material at Landfill - BFI Blue Ridge Landfill - Pearland, Texas

On February 15, 2001, the landfill notified the Agency that trash from a residential area had activated its radiation alarm. An Agency investigation found contaminated kitty litter in a small trash bag. An individual whose name was on correspondence in the bag was contacted. The pet owner confirmed her cat had undergone a nuclear medicine procedure. The veterinarian indicated the cat was released under authorized procedures. However, the owner did not follow instructions to store the litter for decay. To prevent a recurrence, the pet owner was contacted and instructed to store the litter for a designated time before disposal in the routine trash.

File Closed.

I-7735 - Overexposure - Texas NDT Company - Pasadena, Texas

During a routine inspection of the Licensee's facility on December 15, 2000, an Agency inspector noted a 5,030 millirem exposure to a radiographer for the year 1999 monitoring period. The Licensee was cited for the allowing the exposure and failure to notify the Agency.

File Closed.

I-7736 - Overexposure - Petrochemical Inspection Company - Houston, Texas

On December 6, 2000, the Licensee notified the Agency that a radiographer received a 5,670 millirem exposure during the 1999 monitoring period. The radiographer was transferred from location to location in Texas, California, and New Mexico to perform jobs. The Agency was notified by the State of California. A different badge was worn in each state. Upon totaling the exposures, the Licensee became aware of the overexposure. The radiographer was removed from radiation work from June of 1999 through the end of the year. The Licensee believes the exposure resulted from long work hours and improper use of the personnel monitoring device. To prevent a recurrence, the radiographer was disciplined. The Licensee was cited for permitting an individual to receive radiation exposures greater than the annual limits and for failure to notify the Agency.

File Closed.

I-7737 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7738 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7739 - Overexposure - Pain Net Medical Group - Dallas, Texas

On March 28, 2001, the Registrant notified the Agency of a 10,308 millirem exposure to a physician during the year 2000 monitoring period. The Registrant's investigation indicated that the fluoroscopy unit received a new C-arm in May 2000 and the orientation of the x-ray tube and the imaging tube was changed from the x-ray tube below the table with the imaging tube above the table to the x-ray tube above the table with the imaging tube below the table. The physician's average monthly exposure doubled. The Registrant believes the increased exposure was because of the closer proximity of the x-ray tube above the table. In January 2001 the x-ray tube and imaging tube were reversed and the average monthly exposures were reduced to the previous averages. The increased average monthly exposures were not noted earlier because the physician's personnel monitoring was not being exchanged at the appropriate intervals. The Registrant was cited for the overexposure and the inappropriate use of personnel monitoring.

File Closed.

I-7740 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7741 - Stolen X-Ray Unit - X-Ray On Wheels - Corpus Christi, Texas

On March 21, 2001, the Registrant notified the Agency that an x-ray machine located in a mobile van was stolen on March 20, 2001. A Police Report was filed with the Corpus Christi Police Department. The vehicle was recovered on March 28, 2001, with the x-ray unit intact and undamaged.

File Closed.

COMPLAINT SUMMARY FOR FIRST QUARTER 2001

C-1531- Unregistered Laser Demonstration and Sales - Medical Equipment Designs, Inc., Grand Prairie, Texas

On December 19, 2000, the Agency received an anonymous complaint alleging that a facility was unregistered for laser demonstration and sales and also functioned as a provider of laser equipment for temporary rentals. An Agency investigation on April 17, 2001, confirmed that the facility was both unregistered for laser demonstration and sales and was also unregistered as a provider of laser equipment. The facility was cited for the violations.

File Closed.

C-1532 - Unauthorized Screening - Lifeline Imaging d.b.a. Vital View - Houston, Texas

On March 12, 2001, the Agency received a complaint alleging a Registrant was performing unauthorized screening. An Agency investigation determined the Registrant had a physician onsite and procedures were ordered by physicians. The investigation did not substantiate the allegation.

File Closed.

C-1533 - Regulation Violation - First PET of Houston - Houston, Texas

On December 11, 2000, the Agency received an anonymous complaint alleging that radioactive materials were being used and stored at an unlicensed location. An Agency investigation determined that no radioactive materials had been transported to, used, or stored at the complaint location. The investigation did not substantiate the allegation.

File Closed.

C-1534 - Uncredentialed Technologist - Heart Scan Partners - Houston, Texas

On January 5, 2001, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform dangerous and hazardous radiologic procedures. It was alleged that the person performing CT scans has a California certificate, but not a Texas certificate. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1535 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1536 - Regulation Violations - SouthTexas Medical Clinic - Bay City, Texas

On January 4, 2001, the Agency received a complaint alleging that the Registrant,s mammography quality control testing was not consistently performed. An Agency investigation found five violations of regulations. The Registrant failed to cease clinical image processing with the processor when the analysis of a quality control test indicated the limits were exceeded. Charted data indicated tests were within limits, although the tests were not. This occurred in April 1999. The Registrant failed to perform image quality evaluation with the phantom in September 1999. The lead interpreting physician failed to provide direction and oversight for all aspects of the quality assurance program. The Registrant failed to perform processor performance evaluation in December 2000. The Registrant failed to perform repeat analysis at correct time intervals. The repeat analysis was performed once for the entire year 2000. The Registrant was cited for the violations.

File Closed.

C-1537 - Regulation Violations - Greenhouse Day Spa - Dallas / Houston, Texas

On January 15, 2001, the Agency received a complaint alleging that spas in both Dallas and Houston were intentionally exposing patients to laser radiation without authorization of a Texas licensed practitioner of the healing arts. Agency investigations at both locations determined that the facilities did not have a licensed Texas practitioner associated with the facility. The investigation was performed jointly with the Texas Department of Health, Bureau of Food and Drug Safety, Drugs and Medical Devices. Violations of Texas Regulations for Control of Laser Radiation Hazards and conditions of the Certificate of Laser Registration were cited.

File Closed.

C-1538 - Regulation Violations - Southwest Diagnostic Centers - Austin, Texas

On January 17, 2001, the Agency received an anonymous complaint alleging the Registrant did not have a licensed Texas practitioner associated with the facility and did not have interpreting physicians for radiographs. An Agency investigation determined the Registrant was in the process of changing owners and associated physicians. A physicians group was temporarily providing services during the transition. The investigation did not substantiate the allegation.

File Closed.

C-1539 - Regulation Violations - CarePlus Medical - College Station, Texas

On January 22, 2001, the Agency received a complaint alleging that: the x-ray unit was not secure from public access; the facility had no protective walls or barriers; no protective aprons were available to be worn by the technologist or patients; the technologist was not using a personnel monitoring device; the arm of the x-ray unit was sagging and had to be held in place during some exposures; and the entire facility may be unregistered. An Agency investigation determined that the facility was registered with the Agency but had changed their address without notification to the Agency. The Registrant failed to monitor the occupational exposure of the x-ray technologist. The Registrant and the technologist were unable to produce appropriate credentials for authorized use of the facility's x-ray equipment. Other allegations were determined to be invalid. The Registrant was cited for noted violations.

File Closed.

C-1540 - Regulation Violations - Ground Technology Incorporated - Houston, Texas

On January 29, 2001, the Agency received a complaint alleging the Licensee stored a moisture density gauge at an unauthorized location and that gauge users were not trained, but had falsified training certificates. An Agency investigation determined the Licensee had stored a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241 source at the unauthorized location for more than one year. The gauge users had valid training certificates. The investigation determined the radiation safety officer resided outside of the State and was unavailable to perform duties. The Licensee was cited for storage at an unauthorized location, for failure to secure a source of radioactive material from unauthorized removal or access, and for the unavailability of the radiation safety officer to perform duties. The incident was referred for escalated enforcement actions.

File Closed.

C-1541 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1542 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1543 - Uncredentialed Technologist - Physicians Center, PA - Georgetown, Texas

On February 22, 2001, the Agency received a complaint alleging that the Registrant allowed uncredentialed technologists to perform x-ray procedures. An Agency investigation determined that the facility had two uncredentialed personnel performing radiographs. The Registrant was cited for a repeat violation.

File Closed.

C-1544 - Regulation Violations - Austin Radiological Association - Austin, Texas

On February 2, 2001, the Agency received a complaint alleging a Registrant failed to provide a mammogram report. An Agency investigation found no evidence that the mammogram examination was performed. No violations of Agency regulations were noted.

File Closed.

C-1545 - Regulation Violations - Advanced Rehabilitation and Pain Management PA - McAllen, Texas

On March 6, 2001, the Agency received an anonymous complaint alleging that the Registrant: was using an unregistered C-Arm x-ray unit; was not performing personnel monitoring of occupationally exposed personnel; and did not possess sufficient lead aprons or thyroid collar shields for personnel occupationally exposed during operation of the C-Arm. An Agency investigation determined that: the Registrant was using an unregistered C-Arm unit, installed August 17, 1999, without written notification to the Agency; x-ray logs demonstrated that the facility had failed to register within 30 days of commencement of operation of x-ray equipment; the Registrant was not providing personnel monitoring for occupationally exposed personnel; the Registrant had not performed equipment performance evaluations within the required time frames; and the Registrant had not caused required annual fluoroscopic entrance exposure rate measurements to be made on both C-Arm x-ray units. The allegation of insufficient lead aprons and thyroid collar shields was determined to be invalid. The Registrant was cited for the substantiated violations.

File Closed.

C-1546 - Regulation Violations - X-Ray Inspections - Beaumont, Texas

On March 8, 2001, the Agency received a complaint alleging an individual personnel monitoring device was not assigned to and worn by only one individual. An Agency investigation substantiated the complaint. A radiographer who worked for the Licensee for three days wore a badge assigned to a formerly employed radiographer. The Licensee indicated the assignment of a spare badge was intended. The Licensee corrected the exposure records by assessing doses for the September 2000 monitoring period. The Licensee was cited for the violation.

File Closed.

C-1547 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1548 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1549 - Regulation Violations - Body ReNu - Irving, Texas

On March 22, 2001, the Agency received an anonymous complaint alleging that an unregistered laser hair removal facility was: operating without a supervising physician during laser hair removal procedures; using a Medical Director who never saw any patients and did not authorize treatment parameters before exposure to laser radiation; and had burned at least six patients during laser treatments. An Agency investigation determined that: the facility has been unregistered since commencing operation during July 1999; the facility's Medical Director was never on-site during laser treatments but reviewed each patient's request for treatment, medical history, skin typing, and provided treatment parameters to the laser operators before treatments were conducted. The investigation could not confirm the allegation of six patients being burned during laser treatment. The facility was cited for failure to register with the Agency within 30 days of commencing use of the laser. Copies of this complaint and investigation have been forwarded to both the Texas Department of Health's, Bureau of Food and Drug Safety, Medical Devices and the Texas State Board of Medical Examiners for possible actions under their rules/regulations.

File Closed.

C-1550 - Regulation Violations - Richmond Imaging Affiliates, Ltd. - Humble/Conroe, Texas

On March 23, 2001, the Agency received a complaint alleging the wrong patient's name was entered on mammography films. An Agency investigation substantiated the allegation. The Registrant was cited for failure to permanently mark the mammography images with the name of the patient and additional patient identifiers, for failure to perform image quality evaluation with a phantom at no more than 7 day intervals, and for failure to perform darkroom fog tests prior to performing mammography on patients.

File Closed.

C-1551 - Prohibited Use - Prestige Electrolysis - Dallas, Texas

On March 26, 2001, The Agency received a complaint alleging that the Registrant was providing laser hair removal treatments without authorization of a licensed Texas physician, and did not have a licensed physician on-site during laser treatments. An Agency investigation determined that the facility did have a licensed physician authorizing laser treatments under standing orders. The physician was not on-site during most laser treatments. The Registrant was cited for two violations noted during the investigation. Copies of this complaint and investigation have been forwarded to both the Texas Department of Health's, Bureau of Food and Drug Safety, Medical Devices and the Texas State Board of Medical Examiners for possible actions under their rules/regulations.

File Closed.

C-1552 - Unlicensed Source - Port Arthur Bone & Joint - Port Arthur, Texas

On January 23, 2001, the Agency received an anonymous complaint alleging radiopharmaceuticals were delivered to a Registrant who did not have a license to possess or use radioactive materials. An Agency investigation did not substantiate the allegation.

File Closed.

C-1553 - Uncredentialed Technologist - Family Medical - Lewisville, Texas

On March 22, 2001, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform radiographs. An Agency investigation determined that the allegation was valid. The uncredentialed technologist was determined to be using the individual monitoring device of a former employee. The Registrant had not monitored the occupational exposure to the uncredentialed technologist for the period December 2000 through March 15, 2001. The Registrant was cited for the violations.

File Closed.

C-1554 - Unregistered Laser - Total Care Medical Centers, PA - El Paso, Texas

During a routine inspection on March 15, 2001, an Agency inspector noted the unregistered use of a hair removal laser by an x-ray Registrant. The laser was placed in use on January 5, 2001. The Registrant was cited for failure to register the equipment within 30 days of commencement of operation. A copy of the inspection report was forwarded to the Texas State Board of Chiropractic Examiners for possible action under state chiropractic rules.

File Closed.

INCIDENTS CLOSED SINCE FOURTH QUARTER 2000

NO INCIDENTS WERE CLOSED SINCE FOURTH QUARTER 2000

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COMPLAINTS CLOSED SINCE FOURTH QUARTER 2000

NO COMPLAINTS WERE CLOSED SINCE FOURTH QUARTER 2000

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES REPORTED DURING THE FIRST QUARTER 2001

Dallas, Texas

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| <u>* Health and Safety Code-Chapter 241.051(d)</u> | 1 |
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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES REPORTED DURING FIRST QUARTER 2001

Clute, Texas

Non-Destructive Inspection Corporation 3

Houston, Texas

Petrochemical Inspection Company 1

Pasadena, Texas

Technical Welding Laboratory, Inc. 1

Texas NDT Company 1

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APPENDIX C

ENFORCEMENT ACTIONS FOR FIRST QUARTER 2001

Enforcement Conference: METCO - Houston, Texas - Industrial Radiography

On January 18, 2001, an enforcement conference was held with METCO, holder of License No. L03018. METCO representatives attending the conference were Messrs. Mark Clark and Rick Gerads, and Ms. Karen Dupre. Agency representatives were Messrs. Rick Muñoz (Chairman) and William Silva, and Madames Barbara Taylor, Kitty Emerson and Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on September 6, 2000. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The violations and the responses to the violations were reviewed by Ms. Kitty Emerson. The representatives of METCO further responded to the Notice of Violation. After review of the violations and responses, the representatives of METCO were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested that METCO submit a written request to remove Karen Dupre as a Trainer from License No. L03018.
2. METCO shall submit results of field audits for Ms. Dupre to the Agency. Field audits for Ms. Dupre shall be conducted at least 3 times within the next six month period, with no greater than a two month interval between audits.
3. The Agency stipulation for reinstatement for Karen Dupre shall include the submission of all required unannounced field audits and documentation to verify successful completion of a 40 hour Radiation Safety Training course.
4. METCO shall provide a written statement to the Agency indicating they will not add Karen Dupre as a Trainer to License No. 03018, for a period of six months.
5. The Agency increased the inspection frequency for the Houston and Beaumont sites.

6. No Administrative penalties will be assessed at this time. However, pending the outcome of future inspections, administrative penalties may be assessed if any repeat violations, or severity level 1 or 2 violations are noted.

After the caucus, the representatives from METCO returned and were informed of the items discussed during the caucus. The representatives from METCO agreed to these items and the conference was concluded.

Enforcement Conference: Charlton Methodist Hospital - Dallas, Texas - Mammography

On February 6, 2001, an enforcement conference was held with Charlton Methodist Hospital, holder of Certificate of Mammography No. M00378. Charlton Methodist Hospital representatives attending the conference were Mr. Fotis Papanicolaou and Madames Renee Bryant and Jane Cauley. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman) and Jerry Cogburn, and Madames Jo Turkette, Kim Floyd, and Cathy McGuire. Other Health Department observers were Mr. Derek Jakovich, and Ms. Margaret Paynter.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on November 10, 2000. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The violations and the responses to the violations were reviewed by Mr. Jerry Cogburn. The representatives of Charlton Methodist Hospital further responded to the Notice of Violation. After review of the violations and responses, the representatives of Charlton Methodist Hospital were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested that Charlton Methodist Hospital provide a written policy for review of reports for final assessment of findings. Charlton Methodist Hospital agreed to provide a copy of the policy to the Agency within 30 days of the date of this summary.
2. Charlton Methodist Hospital will specify an individual and an alternate who will stop imaging when a quality control measure test exceeds the limits.
3. The Agency requested that the Lead Interpreting Physician for Charlton Methodist Hospital review quality control on a monthly basis for the next 12 months, beginning March 1, 2001.
4. The Agency requested that the Lead Interpreting Physician complete an Agency approved quality control course within 90 days of the date of this summary.
5. The Agency increased the inspection frequency for Charlton Methodist Hospital.
6. No Administrative penalties will be assessed at this time. However, pending the outcome of future inspections, administrative penalties may be assessed.

7. An Agency letter was furnished to Charlton Methodist Hospital indicating the Notice of Failure may be removed from the machine and retained in their files.

After the caucus, the representatives from Charlton Methodist Hospital returned and were informed of the items discussed during the caucus. The representatives from Charlton Methodist Hospital agreed to these items and the conference was concluded.

Enforcement Conference: Hi-Plains Hospital - Hale Center, Texas - Medical

On March 12, 2001, an enforcement conference was held with Hi-Plains Hospital, holder of License No. L03438. The Hi-Plains Hospital representative attending the conference was Mr. Rick States. Agency representatives attending the conference were Messrs. Rick Muñoz (Chairman), Mike Dunn, David Wood and Ms. Cathy McGuire.

The purpose and the procedures of conducting the conference were explained. The conference was held as a result of a facility inspection conducted on November 29, 2000. This inspection determined that the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The violations and the responses to the violations were reviewed by Mr. Mike Dunn. The representative from Hi-Plains Hospital further responded to the Notice of Violation. Mr. States provided some documentation in response to Violations 1a and 1b. No records were available for responses to Violations #1c through Violation #5. After review of the violations and responses, the representative from Hi-Plains Hospital was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Agency requested that Hi-Plains Hospital provide a dose assessment for Harold Coaly for the last 3 months of 1999. Hi-Plains Hospital agreed to provide the information to the Agency within 30 days of the date of this summary.
2. The Agency will recommend assessment of administrative penalties to the Division Director for repeat violations of 1a, 1b, and 1c. A preliminary report for assessment of administrative penalties will be compiled and submitted to Hi-Plains Hospital.
3. The Agency increased the inspection frequency for Hi-Plains Hospital.
4. Pending the outcome of future inspections, additional administrative penalties will be assessed if any repeat violations, or severity level I or II violations are noted.

After the caucus, the representative from Hi-Plains Hospital returned and was informed of the items discussed during the caucus. Clarification from Mr. States was requested concerning the February 28, 2001 letter from Mr. Greg Bruce. Mr. States confirmed amendment of the License to change the RSO from John F. Garvish, M.D. to Rick States. The representative from Hi-Plains Hospital agreed to these items and the conference was concluded.

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